

Home Health & Hospice Newsletter

March 2004



Indiana State
Department of Health

Volume 4
Issue 1

Hospice Consumer Reports

Over the past eight months, providers and state agencies have requested that ISDH develop Web-based reports on hospice agencies. These groups wanted ISDH to create reports that meet two goals:

SERVICE AVAILABILITY

Inform consumers which agencies serve a specific county and how to contact the Council of Aging

COMPLIANCE HISTORY

Provide the consumer a three-year history for each agency's compliance with state or federal laws and rules.

This work is now completed with plans to post in June 2004. A sample report of your agency's results will be mailed at a later time.

Service Availability

The proposed Web site is designed around a map of Indiana. Clicking on the county of interest will display a list of agencies that have reported to ISDH to serve that county.



Each report will display the agency name and address and full-time equivalents and whether the agency accepts Medicare and Medicaid. The report will inform consumers of which services are offered by the agency and if there was a recent change in administrators.

Compliance History

Toward the end of each report, ISDH staff wanted to display a numeric count of the number of state deficiencies, federal citations, and number of substantiated complaints. These counts would not appear for two months after the survey was completed. This delay will ensure all survey results are final.

It is estimated that 70 percent of the reports will acknowledge that the agency has not received a citation in the past three years, or received a complaint that was verified and substantiated.

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HOME HEALTH AIDE REPORTING

On an annual basis, the ISDH requests that every home health agency and hospice identify the number of continuing education hours that every registered home health aide received in that calendar year.

This information can be reported via CD-ROM or on the Record of Continuing Education (State Form 49561). ISDH also requests that you notify us of the number of hours of employment of any CNA in calendar year 2003 via the CD-ROM or on the CNA Renewal form (State Form 49937). This information should be returned to ISDH by May 1, 2004.

This packet includes a list of all RHHAs and CNAs linked to your agency by prior filing. You should review and update that list with new registrations, terminations, and continuing education record on diskette via the CD-ROM.

This packet includes a new version of the CD Aide Registration Renewal program. **This version lets you type the name of that aide only one time**, and then link that aide to the facility number of additional Medicaid or state-only agencies. It is recommended that you retain this CD-ROM in a secure location and destroy older versions.

The ISDH Nurse Aide Registry is authorized by state and federal rules to maintain a registry of certified nurse aides, home health aides, and qualified medication aides. In January 2004, there were 105,768 nurse aides maintained on the registry. That total included 35,950 active certified nurse aides (CNA) and 7,156 active registered home health aides (RHHAs). Roughly half of the RHHAs (3,596) were also CNAs. Since March 1, 2001, ISDH staff has processed 1,565 disks and issued 12,043 letters to individual aides.

Annual Activity Reports

ISDH has enclosed its request for 2004 annual utilization reports, and reminds you of the March 1, 2004 deadline for filing 2003 utilization.

After ISDH has received reports from each home health agency, staff will post statewide and county results at the ISDH Web site at <http://www.in.gov/isdh/regsvcs/acc/hhaserv/index.htm>

The 2002 report reviewed the patient profile of 237 licensed home health agencies and the demographic characteristics of 103,153 clients. In 2002, the average client was female, over age 65 years, and treated for circulatory and musculoskeletal problems.



"The Indiana State Department of Health serves to promote, protect, and provide for the public health of people in Indiana."

Jobs in public service offer many rewards and challenges. If you are interested in a public service career, the Indiana State Department of Health (ISDH) offers a great work environment and the opportunity for personal growth.

The ISDH currently has employment opportunities for nurses, laboratory, and information technology staff as well as a variety of other dedicated professionals.

The ISDH offers a flexible work schedule, a 37.5 hour work week, excellent benefits, and generous paid leave. We rarely require overtime, weekends, or holiday work.

Find out what opportunities await you by checking <http://www.in.gov/isdh/about/hr> or <http://www.in.gov/jobs/stateemployment/jobbank.html>

Equal Opportunity Employer

Indiana State Department of Health

How to Report a Complaint Related to Allegations of Registered Home Health Aide

The Acute Care Division of Indiana State Department of Health is committed to being attentive to any concerns about inappropriate behavior of registered home health aides (RHHA) in Indiana that could be perceived as abuse or neglect of home health clients or that involved misappropriation of patient property (see next column for definitions).

We encourage family members and employees to initially alert the home health agency (HHA) administration of your concerns. This will provide the agency an opportunity to internally address and correct concerns immediately.

If you have done this and feel that further investigation is needed, we recommend a written complaint be prepared and mailed to:

**Acute Care Division
Indiana State Department of Health
2 North Meridian Street, 4-A
Indianapolis, Indiana 46204**

It is recommended that the written complaint includes the following information:

- @ Name, address, and telephone number of complainant, unless the complainant is anonymous.
- @ Name, address, and telephone number of the patient involved in the complaint.
- @ Name of RHHA and any other information that may be helpful in identifying the RHHA.
- @ Name and telephone of RHHA's employer.
- @ Name, address, and telephone of any witnesses.
- @ Action, if any, taken by RHHA employer to discipline the RHHA and to protect the patient.
- @ Involvement of any law enforcement agencies, including local police, prosecutors, Attorney General or Adult Protective Services.
- @ Statement of facts about the allegation that includes date, time, location, and narration of events.

**Further information about
this process can be
obtained by calling
317.233.7541**



Summary of the Home Health Aide Investigation process

Under Indiana Code 16-27-1.5, ISDH staff must investigate any allegation related to the following definitions:

Abuse means the willful infliction of injury, unreasonable confinement, intimidation, or punishment resulting in physical harm, pain, or mental anguish.

Misappropriation of patient property means the deliberate misplacement, exploitation, or wrongful, temporary or permanent use of patient's belonging or money without the patient's consent.

Neglect means failure to provide goods and services necessary to avoid physical harm, mental anguish, or mental illness.



After a complaint is filed, the following ISDH actions will occur
Notification ISDH staff will notify all home health agencies that have previously registered the RHHA and the RHHA that an allegation has been received.

Fact Finding/Investigations

ISDH staff may request the complainant and the RHHA's employer to provide additional information about the incidence and agency records and policies. Based on this information, ISDH staff may request additional written information and may conduct telephone interviews of the RHHA, agency personnel,

and law enforcement officials. All information containing summaries of the interviews and written documentation will be placed into a confidential file.

Independent Legal Review

Upon completion of the investigation, a copy of the complete file shall be referred to the contract legal investigator for review. That individual may collect additional information and conduct more interviews. That individual will determine if there is sufficient evidence to make a preliminary determination of a Finding of Abuse/Neglect, or Misappropriation. That recommendation will be forwarded to the Office of Legal Affairs.

Preliminary Determination of a Finding of Abuse/Neglect or Misappropriation

After a final legal review, the Director will notify all parties that (a) there was insufficient evidence to support a finding, or (b) notify the RHHA that a preliminary finding has been made by the Department. In the latter case, the aide will be offered the opportunity of a written request for a hearing, and later appeal.

Findings

When the finding is final, the finding will be placed on registry, and all parties will be notified that federal and state law prohibits an licensed health care entity from employing this RHHA as a nurse aide or home health aide.

OASIS NEWS

SUSPENSION OF NONMEDICARE/NONMEDICAID PATIENT DATA

Effective 11/5/03, Medicare and Medicaid home health agencies are no longer required to collect OASIS information on private pay patients. While a comprehensive assessment is still required, the assessment does not need to include the OASIS items. The assessment for any patient that would have a payer source identified as 1, 2, 3, or 4 on MO 150 would still require the OASIS items. While CMS has required the collection of OASIS for all skilled patients, the assessments for private pay patients have never been transmitted and, therefore, never used by CMS in the preparation of reports. At such a time that CMS finds a way to use the information, the requirement may be reinstituted.

MO 464

You've been caring for your patient with a pressure ulcer and the ulcer is finally healed. How do you code MO464? CMS says that you should code this question with the answer 1, "Fully granulating." There is really no response that identifies that the ulcer has healed. The answer 4, "No observable pressure ulcer", means that the ulcer is unable to be observed, perhaps due to the presence of a dressing or cast. This response would not be accurate. Therefore, the best response is "fully granulating." CMS is aware that there is not a really good answer for this question when the ulcer is healed. They will look at this issue for future updates. Until then, code healed ulcers as "fully granulating."



OASIS TRAINING

Because of staff changes, your staff may need to be updated on OASIS. Where can you go for training? CMS sent each provider an "OASIS Learning Customized by You" training CD on December 15, 2003. Agencies are free to make copies of the training CD as necessary. This CD is a secondary source to the full OASIS training found on the website, www.oasistraining.org. The website is updated at intervals and, therefore, is the primary source of information.

WOUND CARE MANAGEMENT SATELLITE PRESENTATION

Mark your calendar for a CMS sponsored satellite presentation on wound care. The date is April 23, 2004, 1:00 PM to 3:30 PM EST. When more information is available, ISDH will post it on the "Bulletins" page.

OASIS NEWS, Continued

3 BAR REPORTS—IMPROVED QUALITY OF CARE

You probably already know that 3 bar OBQI reports are now available. The new report allows your agency to compare its performance to that of the previous year for each of the 41 outcomes. More specifically, you will be able to see if the Action Plan you developed and implemented achieved the desired result for the target outcomes you selected. The Health Care Excel staff has been helping agencies throughout Indiana develop and implement plans to improve their performance on selected target outcomes. Please utilize this free resource to help improve the quality of care provided by your agency. A supplement to the OBQI Implementation Manual, dated May 2003, is available on the OASIS Web site and through the "Bulletins" page.

Beginning in early November, CMS made the results of 11 of your agency's outcomes available to the public via the Web. The HOME HEALTH COMPARE data is provided for all Medicare providers. Health Care Excel has provided resource binders that include plans of action, interventions, references, and other relevant information for each of the reported outcomes. If you have not received these outstanding resources, they can be downloaded from (www.hce.org).

ENHANCED SURVEY PROTOCOLS

If you thought that surveyors did not utilize your agency's reports, think again. Last fall, CMS directed the surveyors to use the agency's OBQI, OBQM, and other OASIS related reports to focus federal surveys. Eight adverse events are targeted as well as 10 OBQI outcomes. The Case Mix Report is utilized to identify significant conditions or diagnoses for investigation. The surveyors also review the agency's OASIS Monthly Submission Report and the OASIS Error Summary Report to identify if the agency has met the identified criteria. Your agency could be facing a Partial Extended survey before the surveyor enters the agency if the criteria are not met.

ERROR SUMMARY REPORT

Medicare and Medicaid agencies have the capability to access an Error Summary Report for their agency. ISDH is able to access an "Error Summary Report by State" for Indiana. This report identifies the percentage of the most common errors for the OASIS assessments submitted in Indiana. Interestingly, the most common error is #102, Inconsistent Lock Date, with 16.05% of the submitted assessments generating this error. If you would like to see this entire report, ISDH has placed it on the "Bulletins" page. Instructions on how the agency can access their Error Summary Report are also posted.

Indiana State Department of Health - Hospice Questions and Answers

- ◆ **Question:** Does a student in an accredited Master's of Social Work Program have to have an undergraduate degree in Social Work to do a Master's level field placement in a Hospice setting? Most of the students in a Master's level program have a bachelor's degree in a related field and are now pursuing a Master's Degree in Social Work. The student would be supervised by an MSW in field placement.

ISDH Response: 42 CFR 418.3, A social worker in Hospice is defined as a person who has at least a bachelor's degree from a school accredited or approved by the Council on Social Work Education. 42 CFR 418.84, Medical social services must be provided by a qualified social worker, under the direction of a physician.

- ◆ **Question:** It is our agency's policies to have the patient resign the Explanation of Benefits and Bill or Rights upon discharge home from the hospital. These are patients that never left our service and did not change from one program to another. The patient was admitted to the hospital with other diagnosis unrelated to hospice and the hospice continued to follow for hospice services. (Hospice to Home Health or vice-versa.) Is this necessary?

ISDH Response: What regulatory reference in 42 CFR 418 inspired your policies if the patient is an inpatient? If your agency has a policy, we would hold you to your policy. ISDH staff could not find a regulatory reason to have the patient resign the documents (with the exception that your policy requires the patient to resign) unless there was a change in benefits or rights.

- ◆ **Question:** Why are the surveyors continuing to insist that the percentage of volunteers to direct staff patient care hours must increase each year from the prior year because the regulations say we must show a "continuing level." The Interpretive Guidelines state that once the 5% threshold has been reached, the percentage can fluctuate. Eventually, you are going to hit a percentage that cannot go any higher and might drop down to 20 or 30%. It's not that we get deficiencies, but we still have to go through enormous mathematical mechanisms when we're already in double digits just to prove that it's gone above the prior year.

ISDH Response: Surveyors are required to assess compliance of hospice agencies with the Conditions of Participation (CoP). In 42 CFR 418.70(e) Standard Level of Activity states, "A hospice must document and maintain a volunteer staff sufficient to provide administrative or direct patient care in an amount that, at a minimum, equals 5 percent of the total patient care hours of all percent of the total patient care hours of all paid hospice employees and contract staff. The hospice must document a continuing level of volunteer activity. Expansion of care and services achieved through the use of volunteers including then types of services and the time worked, must be recorded." The interpretive guidelines state, "A hospice may fluctuate the volume of care provided by volunteers after the hospice meets the required 5% minimum."

ISDH does not understand the third sentence in your question as the agency would have to do the calculations to show compliance. The surveyor would look at documentation presented by the agency that demonstrates at least the 5 % minimum has been met and the services provided. What might be seen in future years with a hospice is fluctuation of 5% to higher %, but should always be at the minimum (5%). ISDH would look at all volunteers staff (RN's, LPN's, Homemakers, Home health aides, and others) with the exception of fund raising support staff. ISDH does not mandate how the hospice documents, but wants to see the evidence that the hospice is in compliance.

- ◆ **Question:** Is there an expected number of volunteer hours required for orientation?

ISDH Response: 42 CFR 418.70(a), Standard: Training states, "The hospice must provide appropriate orientation and training that is consistent with acceptable standards of hospice practice." The interpretive guidelines state, "All required volunteer training **should be consistent with the specific tasks that volunteers perform.** What evidence is there that the volunteers are aware of: their duties and responsibilities; the person (s) to contact if they need assistance and instruction regarding the performance of their duties and responsibilities; hospice goals, services, and philosophy; Confidentiality and protection of the patient's rights and families rights; Family dynamics, coping mechanisms and psychological issues surrounding terminal illness, death and bereavement; Procedures to be followed in an emergency, or following the death of the patient; and Guidance related specifically to individual responsibilities?

Question 4 continued...

How does the hospice supervise the volunteers? Is there evidence that all the volunteers have received training or orientation before being assigned to a patient/family? Volunteers who are qualified to provide professional services should meet all standards associated with their specialty area. If licensure or registration is required by the State, the volunteer must be licensed or registered." ISDH surveyors would look at the standards of practice the hospice has identified as their standard, at any policies and procedures, and job description and training required for paid staff in same position to evaluate if orientation and training was met. Since most Hospice use the National Hospice Organization training modules, does the National Hospice Organization require a specific number of hours with their training program and standards?

- ◆ **Question:** When adding a new office site (utilizing the same provider number) how far away (time or mileage) can the sites be from each other?

ISDH Response: ISDH sends written request from Hospice providers who request to add an "other site" to the parent location. CMS determines what criteria is acceptable regarding location and distance from parent. Criteria must be met and is not based solely on mileage issues. Another issue to consider is Indiana does not allow reciprocal agreements with other States, so ISDH staff would not recommend or accept other sites with another State when communicating to CMS.

Criteria regarding Hospice multiple sites may be found in the State Operations Manual (SOM) at 2081 Hospice- Multiple locations state,

Neither the statute nor the hospice regulations provides for establishing hospice "satellite" offices. Nonetheless, a hospice is not precluded from providing services at more than one location if certain requirements assuring quality of care are met and these locations are approved by the Region Office (RO). The RO, in order to support Centers for Medicare and Medicaid Services (CMS)'s responsibility to protect the Medicare trust fund against excessive and unnecessary cost will also ensure that the locations promote cost effective health care. This includes reimbursing hospices at a rate that has been established for the local area. The RO will make a final determination on both quality and cost effectiveness issues with the assistance of the State agency and the fiscal intermediary, if necessary, and will notify all parties of its decision.

To support our concern for quality, CMS requires a hospice who provides services at more than one location, to comply with the following:

- i. The hospice must be able to exert the supervision and control necessary at each location to assure that all hospice care and services continue to be responsive to the needs of the patient/family at all times and in all settings. Hospice care requires the closest of interventions and a distant "parent" cannot provide the immediate access needed to ensure health and safety;
- ii. Each location must provide the same full range of services that is required of the hospice issued the provider number;
- iii. Each location must be responsible to the same governing body and central administration that governs the hospice issued the provider number, and the governing body and central administration must be able to adequately manage the location and assure quality of care at the location; and;
- iv. All hospice patients' clinical records requested by the surveyor must be available at the hospice site issued the provider number.

If a proposed hospice location does not meet the above criteria for quality and cost effectiveness, it must seek Medicare approval as a separate hospice with its own provider agreement and provider number. If the hospice does operate multiple locations, a deficiency found at any location will result in a compliance issue for the entire hospice."

Disclaimer: ISDH is providing the material contained in these questions and answers as a general information resource. It is not legal advice or opinion. As with any general information, the answers given here may not specifically apply to all agencies. This information is based on ISDH understanding of the question posed above and using current rules and regulations as of February 17, 2004. Changes made to rules or regulations after February 17, 2004, may change the written response. Agency policy, procedure or contracts may be more stringent than the rule or regulation. If so, the agency will be required to follow its own, more stringent standard. The CMS/ISDH response is intended to apply only to the question asked.

- ◆ **Question:** What credentials do hospice chaplain and spiritual counselors need?

ISDH Response: Look at 42 CFR 418.72 Condition of participation-Licensure, that states, "The hospice and all hospice employees must be licensed in accordance with applicable Federal, State, and local laws and regulations" and 42 CFR 418.72(b), "Employees who provide services must be licensed, certified or registered in accordance with applicable Federal or State laws."

Spiritual Counseling is found at 42 CFR 418.88 (c) "Spiritual counseling must include notice to patients as to the availability of clergy as provided in 418.70(f)."

Bereavement Counseling is found at 42 CFR 418.88(a) "There must be an organized program for the provision of bereavement services under the supervision of a qualified professional." The interpretive guidelines state, "Bereavement counseling is provided based on and assessment of the family/caregiver's needs, the presences of any risk factors associated with the patient's death, and the ability of the family/caregiver to cope with grief. The supervisor of bereavement services may be the IDG social worker or other professional with documented evidence of training and experience in dealing with grief." The interpretive guidelines also state, "At a minimum the hospice should discuss the patient's religious preference, if any, and assist the patient in evaluation his or her spiritual needs." Most spiritual counselors have some sort of degree in theology or are at least ordained by their particular denomination. ISDH surveyors would look at the agency's standards of practice or policies and procedures for clergy, counselors, and bereavement counselors. ISDH would look at qualifications in the personnel file and documentation that evidence of training and experience in dealing with grief. The hospice should look at what State and local laws govern clergy and counselors.

- ◆ **Question:** Can a hospice have a "workstation"?

ISDH Response: CMS and ISDH do not acknowledge, encourage, or approve workstations. A hospice may apply for "other sites" that are approved by CMS. When ISDH receives a complaint that an agency has an unapproved other site or an unlicensed hospice, ISDH will investigate to see if the site meets criteria to be a hospice or other site. Appropriate action is taken based on findings from the complaint investigation. The surveyor would look to see that this work area does not advertise the location with address signage or telephone number, does not have personnel files or medical records onsite, and does not have staff working routinely at the location taking referrals, physician orders, or running acting informally as "other site" etc.

- ◆ **Question:** How does hospice write orders on Plan of Cares for inpatient units?

ISDH Response: 42 CFR 418.98(a), Inpatient care for pain control and symptom management must be provided in one of the following: (1) A hospice that meets the condition of participation providing inpatient care directly as specified in 418.100. (2) A hospital or a SNF that also meets the standards specified in 418.100 (a) and (e) regarding 24-hour nursing service and patient areas. 42 CFR 418.100 states "A hospice that provides inpatient care directly must comply with all of the following standards. (a) Twenty-four hour nursing services (1) The facility provides 24-hour nursing services which are sufficient to meet total nursing needs and which are in accordance with the patient plan of care. Each patient receives treatments, medication, and diet, as prescribed and is kept comfortable, clean, well-groomed, and protected from accident, injury, and infection. (2) Each shift must include a registered nurse who provides direct patient care." The guidelines state, "Twenty-four hour nursing care requires that the hospice have the number and type of personnel sufficient to meet the total needs of the patient. A registered nurse must be on duty in the facility during each shift." 42 CFR 418.56(e) Inpatient care (1) states, that the hospice furnishes to the inpatient provider a copy of the patient's plans of care and specifies the inpatient services to be furnished. 42 CFR 418.58 states "a written plan of care must be established and maintained for each individual admitted to a hospice program, and the care provided to an individual must be in accordance to the plan." 42 CFR 418.58(a) "The plan must be established by the attending physician, the medical director or physician designee and interdisciplinary group prior to providing care...(c) The plan must include an assessment of the individual's needs and identification of services including the management of discomfort and symptom relief. It must state in detail the scope and frequency of services needed to meet the patient's and family's needs." ISDH Surveyors have accepted plans of care in inpatient units that have frequency of visits for (Skilled Nurse) SN, every 8 hour shift/3 shifts per day/7 days per week or SN 24 hours per day/7days per week.

The plans of care state in detail the services that the SN would be providing such as assessing patient, assessing pain, administering medications, performing dressing changes and treatments, diet, etc. (All care that is being provided by staff should be on the plan of care.) The plans of care should also include any other disciplines providing service (HHA, volunteers, pastoral or counselor, social worker) and the frequency and details of those services). **The above response relates to patients categorized by payment regulations as "general inpatient and respite inpatient" and does not pertain to patients who live in the inpatient unit as the place of residence and are categorized by payment regulations as "routine home care". Routine home care hospice patient's plans of care must follow 42 CFR 418.58.**

Branch Identification Numbers

The Centers for Medicare and Medicaid Services has assigned identification numbers to all approved branch offices of a Medicare certified parent home health agencies. Branch identification number(s) must be entered in MO 16 on all OASIS assessments submitted after 1/1/04. In the future, the agency will be able to obtain outcome reports for a specific office.

Branch numbers are based on the agency's provider number and each number will be used only once. In the event that a branch closes, that identification number will be terminated. The agency must use the branch number when requesting changes, submitting information, or asking questions related to a specific branch.

Name, Addresses, Administrative Staff Changes-Reminder

All home health agencies in Indiana are required to notify the Indiana State Department of Health, in writing, regarding changes of facility name, address, Administrator, Alternate Administrator, Nursing Supervisor, and Alternate Nursing Supervisor. The notification should be on agency letterhead and include the facility number and provider number, if any, and the effective date of the change. When a change of staff is submitted, the agency must also include a current Indiana Registered Nurse license (if applicable), a current limited criminal history check, and a resume that identifies the required experience for the position.

Hospice agencies also need to ensure that their name, address, and administrative positions are maintained accurately in the ISDH data base. The notification should be on agency letterhead and include the facility number and provider number, if any, and the effective date of the change. For changes in the position of Hospice Administrator, please submit the name of the Administrator; for the Medical Director, include a current Indiana MD license; and for the Patient Family Coordinator, include a current Indiana RN license.

Telephone Directory by Topic

Plans of Correction Survey Process

Lana Richmond 317.233.7742

Provider Changes, Licensure, Initial Application, & Closures

Darlene Earls 317.233.7302

OASIS Technical Help Desk

317.233.7203

OASIS Clinical Coordinator

Joyce Elder
317.233-7203

Data Reporting & Aide Registry

Tom Reed 317.233.7541

Home Health & Hospice Information on ISDH Web Site

- ◆ Directory (with quarterly updates)
- ◆ Laws/Rules/Regulations (USA & IN)
- ◆ Licensing Form
- ◆ Reports
- ◆ Links to various organizations
www.in.gov/isdh/regsvcs/providers.htm

The Home Health & Hospice Newsletter

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